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[redacted]

National Medical Director
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19th December 2024

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Aran Sean Bradbury who died on 25 August 2023.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 24 October 2024 concerning the death of Aran Sean Bradbury on 25 August 2023. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Aran's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Aran's care have been listened to and reflected upon.

In your Report you raised concerns regarding the coding of the 25-C code subsets, which are defined by the Emergency Call Prioritisation Advisory Group (ECPAG). Specifically, you raised that patients with a history of mental illness, who might otherwise warrant a Category 2 ambulance prioritisation, could be prioritised as Category 3 instead due to the system, resulting in a longer waiting time. NHS England has liaised with the Chair of the NHS England ECPAG to inform this response.

Ambulance Emergency Operation Centres (EOCs) use one of two approved triage tools to code 999 emergency calls – Advanced Medical Priority Dispatch Systems, (AMPDS) or NHS Pathways. The outcome (disposition) reached at the conclusion of the initial assessment must be mapped to approved, contracted standards. There is a requirement to map these outcomes to the various categories (Categories 1 – 5) set out within the NHS Constitution and Ambulance Service 999 contracts. Category 5 (originally Category 4H) relates to calls that do not require an ambulance response; there is no standard for Category 5 calls.

The grading of 999 calls are clinically based decisions and any changes are considered by the NHS England ECPAG, based on receipt of a review of the evidence base with formal recommendations from the NHS England Clinical Coding Review Group, with endorsement of the clinical rationale of proposed changes by the Association of Ambulance Chief Executives' National Ambulance Service Medical Directors group (NASMeD). Any recommendations that are made and implemented will be formally reviewed with ongoing monitoring from ECPAG.

There are over 1,700 AMPDS dispositions and 219 dispositions used in NHS Pathways for 999, which are mapped to one of the response categories, which individual ambulance services are required to comply with.

The mapping of a patient to an initial response category is only the first step; ambulance services have robust clinical oversight safeguards in place for patients presenting with overdose and suicidal ideation. EOCs follow specific principles on their respective triage tool to ensure clinical oversight is rapidly initiated. These principles have been reviewed and strengthened through several national recommendations since 2019.

Firstly, on 2 April 2019, [redacted] – the then National Clinical Director for Urgent and Emergency Care at NHS England – wrote to ambulance trusts and NHS 111 providers to mandate that robust clinical oversight was in place in control rooms and call centres to monitor self-harm and suicidal patients safely and effectively.

Secondly, in 2020, the then Healthcare Safety Investigation Branch (HSIB), now the Health Services Safety Investigations Body (HSSIB), investigated the potentially under-recognised risk of harm from the use of propranolol. They made a safety recommendation for NHS England to evaluate current approaches to clinical oversight of overdose calls within ambulance control rooms, and to develop a national framework to describe requirements for appropriate clinical oversight of overdose calls.

NHS England issued internal guidance to ambulance services relating to overdoses and suicidal intent in April 2021. The guidance highlights the critical importance of clinical oversight and review and sets out that:

- where a potential threat of suicide is declared, an urgent clinical review should take place within 30 minutes, or the case must be automatically upgraded to a Category 2 if this does not occur within 40 minutes.
- the initial clinical review should consider any ongoing suicidal ideation with a specific plan / means.

Most recently, the overdose guidance was updated in November 2023 to include callers who reach a Category 5 disposition (hear and treat). This followed a review by ECPAG, NHS England and NASMeD to ensure it remained clinically fit for purpose.

You raised concerns in your Report regarding the coding of the 25-C code subsets. The AMPDS sub-group of ECPAG has escalated the issue with the 25-C codes to the International Academies for Emergency Dispatch for rapid resolution, to amend the software used to triage calls through AMPDS.

NHS England's ECPAG has since written to all ambulance trusts asking them to confirm full compliance with all aspects of the NHSE guidance on '999 overdose and suicidal ideation calls' and asking AMPDS trusts to confirm they have ensured that any calls where a 25-C-1 (any/no suffix), 25-C-2 (any/no suffix) or 25-C-4 (any/no suffix) determinant is reached, are amended to a Category 2 if there is use of medications or substances, until a software update is implemented.

I would also like to provide further assurances on the national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors, and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around events, such as the sad death of Aran, are shared across the NHS at both a national and regional level and helps us to pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

[redacted]
National Medical Director